STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

April 19, 2018

Mike Summerer, Administrator
John Dempsey Hospital
263 Farmington Avenue
Farmington, CT 06032

Dear Dr. Summerer:

Unannounced visits were made to John Dempsey Hospital on January 24 and 25, 2018 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting multiple investigations.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by May 3, 2018 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice. The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;
(2) the date each such corrective measure or change by the institution is effective;
(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and
(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

DATES OF VISIT: January 24 and 25, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Susan Newton, R.N., B.S.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN:lst

CT #'s 20903, 21904

DATES OF VISIT: January 24 and 25, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B) and/or (d) Medical Records (3) and/or (e) Nursing Service (1).

1. Based on review of clinical records, hospital documentation, and interviews for one of two patients reviewed for outpatient surgical procedures, Patient #1, the hospital failed to ensure that the clinical record accurately identified the surgical procedure performed and/or the correct laterality of the initial injury and subsequent surgery. The findings include:
   a. Review of the clinical record identified that Patient #1 arrived at the hospital's surgical center on 11/3/2016 at 10:25 AM. Diagnoses included displaced fracture of the proximal phalanx of the right index finger. A signed authorization for an orthopedic surgical procedure identified right index finger open reduction and internal fixation, proximal interphalangeal joint dislocation and possible hemihamate autograft (bone graft). Review of the nursing intraoperative record and the operative note identified that the procedure started on 11/03/16 at 1:21 PM and was completed at 3:32 PM. Patient #1 was transported to the Post-Acute Care Unit (PACU) at 3:47 PM. The procedural information included open treatment of interphalangeal joint dislocation with, or without, internal or external fixation, right; arthroplasty of the interphalangeal joint, and bone graft. Patient #1 was discharged from the PACU at 5:03 PM and transported to medical (med)/surgical (surg) unit 5. A Patient Procedure Hand-Off Communication Form (ISBAR) identified that RN #1, from the PACU, reported off to RN #2, from med/surg unit 5 on 11/3/16 at 5:11 PM that Patient #1 was status post right thumb open reduction and internal fixation (in error). A med/surg outpatient post procedure nursing assessment documented by RN #2 at 5:45 PM identified that Patient #1's reason for procedure was status post right thumb open reduction and internal fixation (in error). The post procedure note dated 5:45 PM included that the patient was at the hospital for a right thumb open reduction and internal fixation (in error) per unit protocol and the patient tolerated the procedure well without difficulty. Patient #1 was discharged from the med/surg 5 outpatient unit at 7:00 PM.

      Interview and review of the ISBAR and the med/surg 5 outpatient post procedure nursing assessment flowsheet with RN #1 on 1/26/18 at 11:40 AM identified that the procedure/test documentation was incorrect and could have been reported or transcribed incorrectly.

      Review of a follow-up evaluation dated 11/18/2016 by MD #4 and authenticated by MD #3 identified that Patient #1 was two weeks status post left index finger proximal interphalangeal (PIP) fracture dislocation of the base of the middle phalanx. Throughout the evaluation, the laterality of the injury as well as the surgical site was described as left index finger. The initial injury and surgical procedure involved the right index finger.

Accepted 5/3/18 SHN

Violation	Discussion of Issues	Measures to Prevent Reoccurrence/Date Corrective Action Effected/Responsible party
The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical Staff (2)(B) and/or (d) Medical Records (3) and/or (e) Nursing Service (1).	1. Based on review of clinical records, hospital documentation, and interviews for one of two patients reviewed for outpatient surgical procedures, Patient #1, the hospital failed to ensure that the clinical record accurately identified the surgical procedure performed and/or the correct laterality of the initial injury and subsequent surgery. The findings include: a. Review of the clinical record identified that Patient #1 arrived at the hospital's surgical center on 11/3/2016 at 10:25 AM. Diagnoses included displaced fracture of the proximal phalanx of the right index finger. A signed authorization for an orthopedic surgical procedure identified right index finger open reduction and internal fixation, proximal interphalangeal joint dislocation and possible hemihamate autograft (bone graft). Review of the nursing intraoperative record and the operative note identified that the procedure started on 11/03/16 at 1:21 PM and was completed at 3:32 PM. Patient #1 was transported to the Post-Acute Care Unit (PACU) at 3:47 PM. The procedural information included open treatment of interphalangeal joint dislocation with, or without, internal or external fixation, right; arthroplasty of the interphalangeal joint, and bone graft. Patient #1 was discharged from the PACU at 5:03 PM and transported to medical (med)/surgical (surg) unit 5. A Patient Procedure Hand-Off Communication Form (ISBAR) identified that RN #1, from the PACU, reported off to RN #2, from med/surg unit 5 on 11/3/16 at 5:11 PM that Patient #1 was status post right thumb open reduction and internal fixation (in error). A med/surg outpatient post procedure nursing assessment documented by RN #2 at 5:45 PM identified the Patient #1's reason for procedure was status post right thumb open reduction and internal fixation (in error). The post procedure note dated 5:45 PM included that the patient was at the hospital for a right thumb open reduction and internal fixation (in error) per unit protocol and the patient tolerated the procedure well without difficulty. Patient #1 was discharged from the med/surg 5 outpatient unit at 7:00 PM. Interview and review of the ISBAR and the med/surg 5 outpatient post procedure nursing assessment flowsheet with RN #1 on 1/26/18 at 11:40 AM identified that the	1a. **Action:** The process of transferring a DOC outpatient is different than other patients as they are not discharged home but rather go to a holding areas to await transportation back to their facility. Training of nurses in the PACU and Department of Corrections (DOC) unit regarding communication of a DOC patient having outpatient orthopedic surgery and the handoff communication with the accepting unit was reinforced. On 4/28/2018 a new electronic health record was implemented which will ensure information is accurately shared electronically between departments. **Compliance Monitor:** Audit all DOC outpatient orthopedic surgery patient's charts to assure appropriate documentation of procedure, site and laterality. This audit will be completed for three months. A compliance level of less than 90% will result in continued monthly monitoring until 90% compliance is achieved. **Responsible Person:** Nursing Director of Procedural Services **Completion Date:** 5/4/2018 1b. **Action:** On 4/28/2018 a new electronic health record was implemented which will ensure information is accurately shared electronically between departments. Training of providers regarding confirming procedure including laterality during follow up appointments of DOC patient having outpatient orthopedic surgery was reinforced. **Compliance Monitor:** Audit all DOC outpatient orthopedic surgery patient's follow up charts to assure physician's appropriate documentation of procedure and site including laterality. The audit will be completed for three months. A compliance level of less than 90% will result in continued monthly monitoring until 90% compliance is achieved. **Responsible Person:** Director of Outcomes, Research, and Quality **Completion Date:** 5/4/2018

Violation	Discussion of Issues	Measures to Prevent Reoccurrence/Date Corrective Action Effected/Responsible party
	procedure/test documentation was incorrect and could have been reported or transcribed incorrectly. Review of a follow-up evaluation dated 11/18/2016 by MD #4 and authenticated by MD #3 identified that Patient #1 was two weeks status post left index finger proximal interphalangeal (PIP) fracture dislocation of the base of the middle phalanx. Throughout the evaluation, the laterality of the injury as well as the surgical site was described as left index finger. The initial injury and surgical procedure involved the right index finger.	